		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020610

Facility Name: Wabash Christian Retirement

Address: 216 College Blvd (Number) Carmi (City) 62821 (Zip Code)

County: White

Telephone Number: 618-382-4644 **Fax #** ( )

IDPA ID Number: 37-0841562002

Date of Initial License for Current Owners: 1974

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2000 to June 30, 2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,536	8,105		30,641	8
9	SNF/PED					9
10	ICF	11,572	6,046		17,618	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,108	14,151		48,259	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.64%

D. How many bed-hold days during this year were paid by Public Aid? 291 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 06/01/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Wabash Christian Retirement # 0020610 **Report Period Beginning:** July 1, 2000 **Ending:** June 30, 2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	230,428	24,796	22,607	277,831		277,831		277,831			1
2	Food Purchase		198,926		198,926		198,926	(39)	198,887			2
3	Housekeeping	90,353	24,531	4,333	119,217		119,217		119,217			3
4	Laundry	117,584	16,736	5,639	139,959		139,959		139,959			4
5	Heat and Other Utilities			155,142	155,142		155,142	607	155,749			5
6	Maintenance	57,160	30,163	60,780	148,103		148,103	8,897	157,000			6
7	Other (specify):*											7
8	**TOTAL General Services**	495,525	295,152	248,501	1,039,178		1,039,178	9,465	1,048,643			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,510,324	71,898	86,012	1,668,234	(3,414)	1,664,820		1,664,820			10
10a	Therapy			9,400	9,400		9,400		9,400			10a
11	Activities	27,156		5,702	32,858		32,858		32,858			11
12	Social Services	75,592	1,604	5,236	82,432		82,432		82,432			12
13	Nurse Aide Training					3,414	3,414		3,414			13
14	Program Transportation		2,173		2,173		2,173		2,173			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,613,072	75,675	109,950	1,798,697		1,798,697		1,798,697			16
	C. General Administration											
17	Administrative	47,931	699	167,983	216,613		216,613	(129,211)	87,402			17
18	Directors Fees											18
19	Professional Services			6,035	6,035		6,035	13,254	19,289			19
20	Dues, Fees, Subscriptions & Promotions			13,221	13,221		13,221	280	13,501			20
21	Clerical & General Office Expenses	46,338	11,482	41,988	99,808		99,808	(1,746)	98,062			21
22	Employee Benefits & Payroll Taxes			358,943	358,943		358,943	3,783	362,726			22
23	Inservice Training & Education											23
24	Travel and Seminar							3,717	3,717			24
25	Other Admin. Staff Transportation			661	661		661		661			25
26	Insurance-Prop.Liab.Malpractice			21,314	21,314		21,314	1,561	22,875			26
27	Other (specify):*							5,934	5,934			27
28	**TOTAL General Administration**	94,269	12,181	610,145	716,595		716,595	(102,428)	614,167			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,202,866	383,008	968,596	3,554,470		3,554,470	(92,963)	3,461,507			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wabash Christian Retirement #0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			133,417	133,417		133,417	6,112	139,529			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			103,138	103,138		103,138	(5,354)	97,784			32
33	Real Estate Taxes			96	96		96		96			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			5,038	5,038		5,038		5,038			36
37	**TOTAL Ownership**			241,689	241,689		241,689	758	242,447			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			6,665	6,665		6,665		6,665			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,600	87,600		87,600		87,600			42
43	Other (specify):* **Apt & Congregate**			81,935	81,935		81,935	(4,378)	77,557			43
44	**TOTAL Special Cost Centers**			176,200	176,200		176,200	(4,378)	171,822			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,202,866	383,008	1,386,485	3,972,359		3,972,359	(96,583)	3,875,776			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(39)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,112	30		9
10	Interest and Other Investment Income	(5,354)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,773)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,378)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(92)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,336)	21		24
25	Fund Raising, Advertising and Promotional	(370)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,035)	21		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,265)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(62,318)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (62,318)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (96,583)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Wabash Christian Retirement

ID# 0020610

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(39)	0	0	0	0	0	0	0	0	0	0	(39)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	607	0	0	0	0	0	0	0	0	0	607	5
6	Maintenance	0	8,897	0	0	0	0	0	0	0	0	0	8,897	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(39)	9,504	0	0	0	0	0	0	0	0	0	9,465	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(129,211)	0	0	0	0	0	0	0	0	0	(129,211)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,254	0	0	0	0	0	0	0	0	0	13,254	19
20	Fees, Subscriptions & Promotions	(370)	650	0	0	0	0	0	0	0	0	0	280	20
21	Clerical & General Office Expenses	(30,236)	28,490	0	0	0	0	0	0	0	0	0	(1,746)	21
22	Employee Benefits & Payroll Taxes	0	3,783	0	0	0	0	0	0	0	0	0	3,783	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,717	0	0	0	0	0	0	0	0	0	3,717	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,561	0	0	0	0	0	0	0	0	0	1,561	26
27	Other (specify):*	0	5,934	0	0	0	0	0	0	0	0	0	5,934	27
28	**TOTAL General Administration**	(30,606)	(71,822)	0	0	0	0	0	0	0	0	0	(102,428)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,645)	(62,318)	0	0	0	0	0	0	0	0	0	(92,963)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Wabash Christian Retirement** **#** **0020610** **Report Period Beginning:** **July 1, 2000** **Ending:** **June 30, 2001**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,112	0	0	0	0	0	0	0	0	0	0	6,112	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,354)	0	0	0	0	0	0	0	0	0	0	(5,354)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	758	0	0	0	0	0	0	0	0	0	0	758	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(4,378)	0	0	0	0	0	0	0	0	0	0	(4,378)	43
44	**TOTAL Special Cost Centers**	(4,378)	0	0	0	0	0	0	0	0	0	0	(4,378)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,265)	(62,318)	0	0	0	0	0	0	0	0	0	(96,583)	45

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc	100.00%	$ 607	$ 607	1
2	V	6	Maintenance				8,897	8,897	2
3	V	17	Administrative	165,684			36,473	(129,211)	3
4	V	18	Directors						4
5	V	19	Professional Services				13,254	13,254	5
6	V	20	Fees, Subscriptions				650	650	6
7	V	21	Clerical				28,490	28,490	7
8	V	22	Employee Benefits	7,950			11,733	3,783	8
9	V	23	Inservice Training						9
10	V	24	Travel&Seminar				3,717	3,717	10
11	V	26	Insurance				1,561	1,561	11
12	V	27	Depreciation				5,934	5,934	12
13	V								13
14	Total			$ 173,634			$ 111,316	$ * (62,318)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: ne 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Carmi (Tax Exempt)		x	Refinance Mortgage	$19,562.50	01/01/90	$ 2,185,000	$ 1,130,000	01/01/10	0.0750	$ 83,184	1
2	Due to CHI Bond Fund	x			$5,000.00	09/01/97	448,612	444,954	09/01/01	0.0850	19,954	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$24,562.50		$ 2,633,612	$ 1,574,954			$ 103,138	9
	B. Non-Facility Related*											
10	City of Carmi		x	Refinance Mortgage		01/01/90	115,000		01/01/10	0.0750	4,378	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 115,000	$			$ 4,378	14
15	TOTALS (line 9+line14)						$ 2,748,612	$ 1,574,954			$ 107,516	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wabash Christian Retirement COUNTY White

FACILITY IDPH LICENSE NUMBER 0020610

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE (217) 732-9651 FAX #: (217) 732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Unavailable		$ 96.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 96.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,480 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Duplex Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	1974	$ 65,910	1
2	Home Office			6,624	2
3	TOTALS	217,800		$ 72,534	3

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1974	1958	$ 1,127,971	$ 26,010	40	$ 28,199	$ 2,189	$ 704,457	4
5	80		1976	1976	637,282	18,121	30	21,243	3,122	461,230	5
6											6
7											7
8	Home Office				47,271	1,544		1,544		20,523	8
	Improvement Type**										
9	Land Improvement			1974			20				9
10	Land Improvement			1978			20				10
11	Building			1978	13,972	399	35	399	0	9,419	11
12	Building Improvements			1979	36,485		18			36,485	12
13	Land Improvement			1979			5				13
14	Land Improvement			1979			5				14
15	Boiler Room			1981	3,648		15			3,648	15
16	Landscaping			1981			10				16
17	Roof Repairs			1981	4,080		3			4,080	17
18	Building Improvements			1982	19,950	798	25	798		14,641	18
19	Electrical Supplies			1982	234	12	20	12	(0)	229	19
20	Rewiring Westside			1982	3,000	150	20	150		2,863	20
21	Guttering			1982	9,567		15			9,567	21
22	Wallcovering			1982	1,750		10			1,750	22
23	TV Systems			1982	2,090		15			2,090	23
24	Heating Control Systems			1982	34,046	1,702	20	1,702	0	32,622	24
25	Light Fixtures			1984	1,432		10			1,432	25
26	Floor Tile			1985	6,641		10			6,641	26
27	Vinyl & Labor			1985	397		10			397	27
28	Sewer Work			1985	20,976	699	30	699	0	11,242	28
29	Nurse Station			1985	7,623	381	20	381	0	6,001	29
30	Hot Water Heaters			1986	4,900	268	15	268		4,900	30
31	Nurse Call Systems			1986	1,179	14	15	14		1,179	31
32	Roofwork			1986	7,235	246	15	246		7,235	32
33	Boiler System			1986	6,061	303	20	303	0	4,545	33
34	Grading			1987			20				34
35	Floor Tile			1987	977		10			977	35
36	Bathroom Remodel			1987	5,615	281	20	281		4,051	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Wallpaper	1988	$ 870	$	5	$	$	$ 870	37
38	Carpeting	1989	1,086		5			1,086	38
39	Carpeting	1989	800		5			800	39
40	Painting & Papering	1989	856		5			856	40
41	Painting	1989	467		5			467	41
42	Light Fixtures (28)	1989	1,341		10			1,341	42
43	Rooftop A/C Unit (2)	1989	6,280		8			6,280	43
44	Roof	1989	81,902	4,095	20	4,095	0	47,093	44
45	Tile	1990	1,231		5			1,231	45
46	Faucets	1990	1,716		10			1,716	46
47	Carpeting	1990	3,236		5			3,236	47
48	Carpeting	1990	2,392		5			2,392	48
49	Carpeting	1990	2,298		5			2,298	49
50	Carpeting	1990	2,799		5			2,799	50
51	Rooftop A/C Unit (2)	1991	4,080		8			4,080	51
52	Fill and Seal Parking Lot	1991			5				52
53	Condensing Unit	1991	1,355	136	10	136	(1)	1,349	53
54	Steel Doors	1991	1,650	110	15	110		1,082	54
55	New Roof	1991	11,931	795	15	795	0	7,751	55
56	Light Fixtures	1991	2,189	219	10	219	(0)	2,099	56
57	Remodel 22 Bathrooms	1992	10,313	516	20	516	(0)	4,859	57
58	Steel Doors	1992	1,650	110	15	110		1,036	58
59	Wallpaper	1992	1,695		5			1,695	59
60	Remodel Lobby/Dining Room	1992	12,246	612	20	612	0	4,896	60
61	Remodel Bathrooms	1992	2,331	117	20	117	(0)	1,092	61
62	Carpeting	1992	2,480		5			2,480	62
63	Rooftop A/C Unit	1992	5,338		8			5,338	63
64	Carpeting	1992	3,166		5			3,166	64
65	A/C Units	1992	1,700		5			1,700	65
66	Remodeling	1992	11,704	585	20	585	0	5,321	66
67	Sound System	1992	1,563	156	10	156	0	1,378	67
68	Water Heater	1992	1,862	124	15	124	0	1,085	68
69	Remodeling	1993	6,615	661	10	662	1	5,405	69
70	TOTAL (lines 4 thru 69)		$ 2,195,524	$ 59,164		$ 64,476	$ 5,312	$ 1,480,481	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,195,524	$ 59,164		$ 64,476	$ 5,312	$ 1,480,481	1
2	Wallcovering/base Trim	1993	2,123		5			2,123	2
3	Sidewalk	1993			15				3
4	Garage Door	1993	848	85	10	85	(0)	659	4
5	New Roof Beauty Shop	1993	4,515	301	15	301		2,283	5
6	Rheem Water Heater	1994	2,270	227	10	227		1,665	6
7	Door	1994	1,365	137	10	137	(1)	993	7
8	Fire Alarm System	1994	26,850	1,343	20	1,343	(1)	9,513	8
9	Driveway	1994			15				9
10	Egress Locks	1994	2,298	230	10	230	(0)	1,533	10
11	Carpeting	1995	545		5			545	11
12	Kitchen	1995	85,264	2,750	31	2,750	0	17,096	12
13	Conc. Trought-Laundry	1995	1,183	118	10	118	0	738	13
14	Remodel Wing	1995	9,535		5			9,535	14
15	Rooftop A/C Unit Eastside	1995	1,800	180	10	180		1,050	15
16	Remodel Wing 8	1996	8,494	897	5	1,699	802	8,494	16
17	Tile Kitchen	1997	2,304	461	5	461	(0)	2,036	17
18	Double Doors	1997	736	147	5	147	0	612	18
19	Resurface Parking Lot	1997			3				19
20	Resurface Employee Parking Lot	1997			5				20
21	Remodel Wing	1998	5,534	1,107	5	1,107	(0)	3,067	21
22	Activity Bathroom	1998	6,101	1,220	5	1,220	0	3,965	22
23	Landscaping - Courtyard	1998			5				23
24	Security Door	1999	984	197	5	197	(0)	575	24
25	Remodeling	1999			5				25
26	Carpeting	1999	903	181	5	181	(0)	407	26
27	Congoleum Flooring	2000	3,540	708	5	708		1,298	27
28	Paint (Wing 4)	2000	3,153	631	5	631	(0)	1,052	28
29	Vinyl Floor Covering	2000	1,770	354	5	354		620	29
30	Vinyl Floor	2000	720	144	5	144		216	30
31	Border & Wallpaper	2000	736	147	5	147	0	221	31
32	Kitchen Vinyl	2000	725	145	5	145		193	32
33	Handrails (58)	2000	1,283	86	15	86	(0)	93	33
34	TOTAL (lines 1 thru 33)		$ 2,371,103	$ 70,960		$ 77,072	$ 6,112	$ 1,551,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,371,103	$ 70,960		$ 77,072	$ 6,112	$ 1,551,063	1
2	3 1/2 ton A/C (Wing 3)	2000	1,900	380	5	380		412	2
3	Trane Furnance and A/C System (Wing 2)	2000	8,164	544	15	544	0	589	3
4	Lamenate Flooring (Bath and Kitchen)	2000	2,091	209	10	209	0	226	4
5	Carpet	2000	1,822	364	5	364	0	425	5
6	Asphalt-Parking Lot	2000			5				6
7	Rock for Water Garden	2000			10				7
8	Aquarium-Sere Garden	2000			10				8
9	Barn 12 x 18	2000			10				9
10	Administative wing remodeling/addition	2000			40				10
11	CARPET (EAST WING)	2000	629	126	5	126	(0)	126	11
12	BUILDING	2000	236,608	5,915	40	5,915	0	6,408	12
13	WING 8 BATHROOM REMODEL	2000	23,246	1,356	10	1,356	0	1,356	13
14	ADMINISTRATIVE WING REMODEL	2000	610	15	40	15	0	18	14
15	ENERGY MANAGEMENT SYSTEM	2001	10,000	222	15	222	0	222	15
16	VINYL WALL PROTECTOR (WALLCOVERING)	2001	517	9	5	9	(0)	9	16
17	NURSE CALL SYSTEM	2001	783	7	10	7	(0)	7	17
18	HEAT/AIR CONTROL SYSTEM DUCTWORK	2001	4,100	114	15	114	(0)	114	18
19	Disposals in 2001		(2,090)					(2,090)	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,659,483	$ 80,221		$ 86,333	$ 6,112	$ 1,558,885	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 390,167	$ 42,879	$ 42,879	$	Various	$ 381,322	71
72	Current Year Purchases	54,692	4,138	4,138		Various	4,138	72
73	Fully Depreciated Assets	153,195						73
74	HO Allocation	41,260	4,259	4,259		Various	33,549	74
75	TOTALS	$ 639,314	$ 51,276	$ 51,276	$		$ 419,009	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Ford Bus	1993	$ 39,450	$	$	$	5	$ 39,450	76
77										77
78	HO Allocation			8,985	1,920	1,920			2,770	78
79										79
80	TOTALS			$ 48,435	$ 1,920	$ 1,920	$		$ 42,220	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,419,766	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 133,417	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 139,529	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,112	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,020,114	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment	$ 471,442	$ 14,417	$ 208,060	86
87	Land	65,910			87
88	Land Improvements	63,140	4,175	50,216	88
89	OBLD & OEQT	6,961	300	4,461	89
90					90
91	TOTALS	$ 607,453	$ 18,892	$ 262,737	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This page is Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$ 1,811	$ 1,207	$	$ 3,018
2	Books and Supplies		238	159		396
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 2,048	$ 1,366	$	$ 3,414
10	SUM OF line 9, col. 1 and 2	(e)	$ 3,414			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist	This page	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	Applicable	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 211,231	$	1
2	Cash-Patient Deposits	21,717		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	354,190		3
4	Supply Inventory (priced at)	30,972		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,075		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 623,185	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,910		13
14	Buildings, at Historical Cost	3,052,745		14
15	Leasehold Improvements, at Historical Cost	92,000		15
16	Equipment, at Historical Cost	646,513		16
17	Accumulated Depreciation (book methods)	(2,226,009)		17
18	Deferred Charges	21,766		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,258,932		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Contract Receivable	18,414		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,930,271	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,553,456	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 32,677	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,717		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,075		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	122,754		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 347,223	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,574,954		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Resident Deposits	89,796		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,664,750	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,011,973	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,541,483	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,553,456	$	48

***(See instructions.)**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,741,203	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,741,203	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(199,720)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (199,720)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,541,483	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,436,378	1
2	Discounts and Allowances for all Levels	(897,353)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,539,025	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,300	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,300	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	847	12
13	Barber and Beauty Care	8,016	13
14	Non-Patient Meals	39	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	305	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,207	23
	D. Non-Operating Revenue		
24	Contributions	52,354	24
25	Interest and Other Investment Income***	31,957	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 84,311	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential/Congregate	135,163	28
28a	Unrealized Investment & Equip Gain/Loss	2,633	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 137,796	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,772,639	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,039,178	31
32	Health Care	1,798,697	32
33	General Administration	716,595	33
	B. Capital Expense		
34	Ownership	241,689	34
	C. Ancillary Expense		
35	Special Cost Centers	88,600	35
36	Provider Participation Fee	87,600	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,972,359	40
41	**Income before Income Taxes (line 30 minus line 40)****	(199,720)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (199,720)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,982	1,982	$ 43,354	$ 21.87	1
2	Assistant Director of Nursing	2,667	2,667	36,336	13.62	2
3	Registered Nurses	9,966	10,763	196,152	18.22	3
4	Licensed Practical Nurses	32,171	34,085	415,813	12.20	4
5	Nurse Aides & Orderlies	93,584	98,477	758,773	7.71	5
6	Nurse Aide Trainees		0			6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director	2,455	2,729	27,156	9.95	9
10	Activity Assistants					10
11	Social Service Workers	7,565	8,408	75,592	8.99	11
12	Dietician		0			12
13	Food Service Supervisor	1,839	1,943	28,223	14.53	13
14	Head Cook		0			14
15	Cook Helpers/Assistants	25,700	27,154	202,205	7.45	15
16	Dishwashers		0			16
17	Maintenance Workers	4,134	4,390	57,160	13.02	17
18	Housekeepers	11,848	12,424	90,353	7.27	18
19	Laundry	12,229	13,716	117,584	8.57	19
20	Administrator	1,773	1,973	47,931	24.29	20
21	Assistant Administrator		0			21
22	Other Administrative	2,570	2,860	22,954	8.03	22
23	Office Manager	1,617	1,799	23,384	13.00	23
24	Clerical	3,509	3,509	28,102	8.01	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator		0			29
30	Habilitation Aides (DD Homes)	3,722	3,722	31,794	8.54	30
31	Medical Records		0			31
32	Other Health Care(specify)		0			32
33	Other(specify) Beauty Shop		0			33
34	TOTAL (lines 1 - 33)	219,331	232,601	$ 2,202,866 *	$ 9.47	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	241	$ 10,164	1.3	35
36	Medical Director	0	3,600	9.3	36
37	Medical Records Consultant	47	2,244	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	0	720	10.3	39
40	Physical Therapy Consultant	104	7,298	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	27	2,102	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	34	1,663	14.3	45
46	Other(specify) Dental Consultant	0	481	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	453	$ 28,272		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arthur Saunders	Administrator		$ 47,931
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 47,931

B. Administrative - Other

Description	Amount
Management Fees	$ 165,684
Employee Bonus Allocation	2,299
TOTAL (agree to Schedule V, line 17, col. 3)	$ 167,983
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ustrand	Legal	$ 4,919
Woodward Pires	Legal	617
Outcome Services of IL	Consulting	349
Stanley Law Office	Legal	150
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 6,035

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,684
Unemployment Compensation Insurance	6,300
FICA Taxes	167,358
Employee Health Insurance	108,000
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	9,936
Employee Physicals	3,637
Employee Uniform Allow	(48)
Workers Comp Med Exp	76
HO Allocation	3,783
TOTAL (agree to Schedule V, line 22, col.8)	$ 362,726

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,598
Health Care Worker Background Check	
(Indicate # of checks performed)	
Quarterly & Annual Fees	2,568
Subscriptions	136
Dues	8,549
HO Allocation	650
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,501

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
HO Allocation	3,717
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,717

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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9													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Wabash Christian Retirement # 0020610 Report Period Beginning: July 1, 2000 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN $4,829.48**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,117** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,600**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? _____ If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(39)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Shafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **To be provided upon completion**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.